

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05045
05043

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Easton Memorial Hosp		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON (RURAL) d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Richard Bauer		4. DATE OF DEATH Month Day Year April 21 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE-27, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CORE MAKER		10b. KIND OF BUSINESS OR INDUSTRY MASS.	9. AGE (In years last birthday) 74 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
11. BIRTHPLACE (County & State, or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME RICHARD BAUER		14. MOTHER'S MAIDEN NAME WILHEMINA BAEHMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 022-05-3424		17. INFORMANT Address MRS. GEORGE ROY N.Y. CITY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19.....; that (I) (we) last saw the deceased alive on....., and that death occurred at....., from the causes and on the date stated above.			
22a. SIGNATURE E. C. H. Schmidt M.D.		22b. DATE 22 April 1962	
22c. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF APR 25, 1962	23c. NAME OF CEMETERY OR CREMATORY SILVERBROOK CREMATORY	23d. LOCATION (City, town or county) (State) WILMINGTON DEL.
24. FUNERAL DIRECTOR'S SIGNATURE Maurice C. Newnam & Son - Easton Md.		25a. REC'D BY REGISTRAR DATE APR 24 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

1904



NAME

RESIDENCE

DATE

TIME

PLACE

REASON

REMARKS

SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05046

05044

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u> d. STREET ADDRESS <u>17X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>BAXTER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>April 25-62</u>	9. AGE (In years last birthday) yrs. <u>3</u> IF UNDER 1 YEAR Months <u>3</u> IF UNDER 24 HRS. Hours <u>3</u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Co. Md.</u>
13. FATHER'S NAME <u>Joseph A. Baxter</u>		14. MOTHER'S MARDEN NAME <u>Esther Lynn Horner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Jos. A. BAXTER - GRASONVILLE MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-25</u> 19 <u>62</u> to <u>4-28</u> 19 <u>62</u> That (I) (we) last saw the deceased alive on <u>4-28</u> 19 <u>62</u> and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above:			
22a. SIGNATURE <u>Donald F. Bartley</u>		22b. DATE SIGNED <u>4-30-62</u>	22c. PHYSICIAN'S NAME (Type) <u>Donald F. Bartley</u>
22d. ADDRESS <u>Easton, Maryland</u>		22e. REC'D BY REGISTRAR <u>4-30-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-30-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	23d. LOCATION (City, town or county) <u>Stevensville Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Jare Church Hill Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

11050

05048

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

11050

Season, 1917

N.Y.

Donald J. Hawley



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05047

05045

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b. 3 hrs. 25 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTON Memorial Hosp.			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 29 EASTON d. STREET ADDRESS 305 NEEDWOOD AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Maude Middle Ethel Last Buckhardt			4. DATE OF DEATH Month 4 Day 25 Year 1962		
5. SEX F			6. COLOR OR RACE W.		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH June 17, 1884		
9. AGE (In years last birthday) 77 yrs.			10. IF UNDER 1 YEAR Months 10 Days 8		
11. IF UNDER 24 HRS. Hours 10 Min. 8			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Emory Wiley			14. MOTHER'S MAIDEN NAME Sarah Chambers		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. 1216-03-7461B		
17. INFORMANT Wm. J. Buckhardt			Address 305 Needwood Ave Easton Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO HASCTD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HASCTD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 4 1/2 year		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4/10/62 to 4/25/62 , that (I) (we) last saw the deceased alive on 4/25/62 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE L. J. Eglender M.D.			22b. DATE SIGNED 4/25/62		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE THEREOF April 27, 1962		
23c. NAME OF CEMETERY OR CREMATORY Spring Hill			23d. LOCATION (City, town or county) (State) Easton Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Charles J. ...			25a. REC'D BY REGISTRAR APR 27 '62		
25b. REGISTRAR'S SIGNATURE Charles J. ...					

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Exhibit 31a 32mm

Exhibit 31a 32mm

Exhibit 31a 32mm

1-2-82

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1-2-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 7/61

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05048
CERTIFICATE OF DEATH
05046

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRASONVILLE d. STREET ADDRESS 17X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORA Middle MAY Last CHANCE		4. DATE OF DEATH Month 4 Day 29 Year 1962	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13-1885
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 29	IF UNDER 24 HRS. Hours 17 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Q.A. Co. MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HANSON MORGAN	
14. MOTHER'S MAIDEN NAME ELLA DADDS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. MR. CLEM CHANCE		17. INFORMANT Address GRASONVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) 332X (a), stating the underlying cause last. DUE TO (c) 332X		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary atherosclerotic heart disease & failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 11 p.m. 30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Grasonville (County) Queen Anne's (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 11:30 AM to 2:30 PM , that (I) (we) last saw the deceased alive on 29 Apr 1962 , and that death occurred at 4:30 PM from the causes and on the date stated above.		22a. SIGNATURE Thorston Harrison M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 30 Apr 62	
22c. PHYSICIAN'S NAME (Type) THORSTON HARRISON		22d. ADDRESS Centreville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/1962	
23c. NAME OF CEMETERY OR CREMATORY Chesterfield		23d. LOCATION (City, town or county) Centreville (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane ADDRESS Church Hill Md		25a. REC'D BY REGISTRAR DATE MAY 7 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Krawe			

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00013

CENTRALS OF BATH

00018

MacLennan

Erasmus

WHITE

Heiseville

Hanson, Morton

Dr. Cunningham

Erasmus

Mr. C. M. Chance, Fraser River

Erasmus

Erasmus

Erasmus

Erasmus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>3 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>5 West St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth W. Dennis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1897</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY _____	
11c. BIRTHPLACE (County & State, or foreign country) <u>Talbot Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>George E. Warrington</u>		14. MOTHER'S MAIDEN NAME <u>Salome O. Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>218-20-5958</u>	
17. INFORMANT <u>Mr. Earle Dennis</u>		Address <u>Easton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction (acute)</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Vascular Disease (years)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> 19 <u>62</u> to <u>4/3</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/1</u> 19 <u>62</u> and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>L. J. EGLESETER</u>		22b. DATE SIGNED <u>4/1/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. J. EGLESETER</u>		22d. ADDRESS <u>Easton Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/6/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>	23d. LOCATION (city, town or county) <u>Easton Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice Newman</u>		25a. REC'D BY REGISTRAR <u>APR 10 1962</u>	
ADDRESS <u>Easton Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Smith</u>	

(M)

07029

St. Louis
Mo.

Dear Sir,
I have the honor to acknowledge
the receipt of your letter of the
10th inst. in relation to the
above matter.

07029

St. Louis
Mo.

Very respectfully,
John W. Brown
Agent

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within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
05050					05048										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)										
a. COUNTY		TALBOT			a. STATE		MD								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		WITTMAN			b. COUNTY		TALBOT								
c. LENGTH OF STAY IN TB		LIFE			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		X WITTMAN								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH										
First		Middle		Last		Month		Day Year							
PERRY		H.		DYOTT, SR		APRIL		4 1962							
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)							
MALE		WHITE		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		OCT 15 1904		37 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR							
Farmer		General		EASTON MD		U.S.A		Months Days Hours Min.							
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME										
EDWARD DYOTT					MAY PAGE										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT					
no					213-16-8530					Mrs Effie M. Dyott, Wittman, Ind					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										12 months					
420.1 DUE TO coronary atherosclerosis										1 year					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY										20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from Jan 1962 to Jan 1962, that (I) (we) last saw the deceased alive on Jan 1962, and that death occurred at M, from the causes and on the date stated above.										22a. SIGNATURE		22b. DATE SIGNED			
Guy M Reeser Sr										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS					
GUY M REESER SR										TILGHMAN MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial										4-17-62		Olivet Cemetery		St. Michaels Ind	
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lamberton Harrison, St. Michaels Ind										DATE APR 10 '62		Curtis S. Thoma			

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Edward Dyott

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FOR STATE
HEALTH DEPT.

05051

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05049

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXFORD (RURAL)</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. Memorial Hospital</u>		d. STREET ADDRESS <u>Oxford Road</u> x	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD- ALLEN EASON</u>		4. DATE OF DEATH Month Day Year <u>April 7 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 22, 1961</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>3 16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXX</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XXX</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>WILLIAM L. EASON</u>		14. MOTHER'S MAIDEN NAME <u>LULIA-ANDREW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>		16. SOCIAL SECURITY NO. <u>XXXX</u>	
17. INFORMANT <u>William L. Eason</u>		Address <u>Oxford Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of Brain due to skull fracture</u> 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - head struck dash board</u>			
20c. TIME OF INJURY Hour <u>8:30</u> <u>pm.</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Oxford Road</u>		20f. (City or town) (County) (State) <u>Easton Talbot Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Thurston Harrison</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THURSTON HARRISON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8 April '62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 10, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam</u>		ADDRESS <u>Easton Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 10 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one signature is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-009772

(M)

0051

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00019

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1901		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		J. H. HARRIS		JAN 15 1901	
PREVIOUS ILLNESS		HISTORY		FINDINGS		REMARKS		SIGNATURE OF ATTENDING PHYSICIAN		DATE	
NONE		NONE		HEART DISEASE		NONE		J. H. HARRIS		JAN 15 1901	
SIGNATURE OF NEXT OF KIN		SIGNATURE OF WITNESSES		SIGNATURE OF EXAMINER		DATE		SIGNATURE OF ATTENDING PHYSICIAN		DATE	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		JAN 15 1901		J. H. HARRIS		JAN 15 1901	

1 FOR STATE HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

05052 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05050

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Tilghman			c. LENGTH OF STAY IN 1b 7 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) none					d. STREET ADDRESS none			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Benjamin Last Ecker					4. DATE OF DEATH Month APR Day 29 Year 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-25-92		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Enginman-ret.		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Aaron Ecker					14. MOTHER'S MAIDEN NAME Emma Null				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unk.		16. SOCIAL SECURITY NO. 705-07-6219		17. INFORMANT Address Plaza 2 1734 George A. Ecker, Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9708 Suicide by overdose sleeping pills DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) H.C.V.D.									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED 4-29-62									
ACTUAL SIGNATURE Lewis Orlicy		EXAMINER'S NAME (Type) WELTY		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 5/3/62		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or country) Tilghman, Maryland		(State)			
23. FUNERAL DIRECTOR W. Hampton Carroll		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR MAY 1 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05053											
05051											
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>11 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				d. STREET ADDRESS <u>134 Dodson Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Ellerbe</u>						4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1962</u>		9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Ellerbe</u>						14. MOTHER'S MAIDEN NAME <u>Helen Whittington</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Helen Ellerbe - St. Michaels</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 focal stelectosis</u> DUE TO (b) <u>Hyaline membrane disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., and that death occurred at..... P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>E.C.H. Schmidt</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <u>22 April 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>						22d. ADDRESS <u>Easton, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-25-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Thomas Mem. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>St. Michaels, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Haskel</u> ADDRESS <u>Easton Md</u>						25a. REC'D BY REGISTRAR <u>APR 27 '62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>			

2-059677

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05054
05052

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EA STON</u> c. LENGTH OF STAY IN 1b <u>7 hrs 59 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FAREAST CAROLINE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EA STON PRESTON</u> d. STREET ADDRESS <u>05X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Ewing</u> First Middle Last			4. DATE OF DEATH <u>4-23-1962</u> Month Day Year				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>April 25 1962</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) <u>7 mo</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Easton Talbot Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Francis Ewing Jr.</u>					
14. MOTHER'S MAIDEN NAME <u>Margaret J. Ewing</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					
16. SOCIAL SECURITY NO. <u>7-11-62</u>		17. INFORMANT <u>Father</u> Address <u>Preston Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 7-26X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs. 59 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Easton</u>		(County) <u>Md.</u>		(State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>4-22-62</u>, 19<u>62</u>, to <u>4-23-62</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>4-23-1962</u>, and that death occurred at <u>2:55 PM</u>, from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald F. Bartley</u>		22b. DATE SIGNED <u>4-25-62</u>		22c. PHYSICIAN'S NAME (Type) <u>Donald F. Bartley</u>			
22d. ADDRESS <u>Easton Md.</u>		22e. REC'D BY REGISTRAR <u>APR 27 '62</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 25, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wood Lawn Cem.</u>			
23d. LOCATION (City, town or county) <u>Easton</u>		(State) <u>Md.</u>		23e. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05055
CERTIFICATE OF DEATH
05053

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTON Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY Talbot c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) St. Michaels d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle Carter Last Favors		4. DATE OF DEATH Month April Day 21 Year 1962	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-15-04	
9. AGE (If years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 6 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES E. Nicholson		14. MOTHER'S MAIDEN NAME CLARA Aych	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 314-36-5285	
17. INFORMANT Leon C. Favors, St. Michaels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest due to acute myocardial injury & due to shock secondary to nephrectomy Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 603X DUE TO (b) to acute myocardial injury & due to shock DUE TO (c) secondary to nephrectomy		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-17-62 to 4-21-62 , that (I) (we) last saw the deceased alive on 4-21-62 and that death occurred at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John N. Robinson M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 4/23/62	
22c. PHYSICIAN'S NAME (Type or print) John N. Robinson M.D.		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 4-25-62	
23c. NAME OF CEMETERY OR CREMATORY Thomas Mem. cem.		23d. LOCATION (City, town or county) (State) St. Michaels, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell ADDRESS Easton Md		25a. REC'D BY REGISTRAR APR 27 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hearn	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05056		Items 3, 4 & 14 Film G310 4/9/62 ink		05054	
1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>9 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>29 Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		1417 L. Washington St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>Feurich</u> Middle <u>Feurich</u> Last		4. DATE OF DEATH <u>April</u> <u>4</u> 19 <u>62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20, 1889</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired AT&T</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (County & State or foreign country) <u>New York City</u>	
13. FATHER'S NAME <u>William Feurich</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. <u>055-10-9181</u>		17. INFORMANT <u>Mrs. Wynne Feurich</u> Address <u>Easton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Congestive Failure, Heart Dis</u> (a), stating the underlying cause last. (c) <u>Generalized Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 yrs</u> <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>10 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-4-62</u> to <u>4-4-62</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4-4-62</u> and that death occurred <u>2:00</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>R. Feurich</u>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)
<u>Burial</u>		<u>April 7, 1962</u>	<u>Maple Grove Mem. Park</u>		<u>Kew Gardens N. Y.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam & Son</u>			ADDRESS <u>Easton Md.</u>		25e. REC'D BY REGISTRAR <u>APR 6 '62</u>
			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>		

(M)

02038

02038

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05057
05055

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 21 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) DENISE LORRAINE HACKETT			4. DATE OF DEATH Month 4 Day 24 Year 1962		
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 8, 1961		9. AGE (In years last birthday) 1 yrs. 8 months 16 days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John E. Baskett	
14. MOTHER'S MAIDEN NAME Eva Hackett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Eva Hackett		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 340.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Meningitis - H. Influenza. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 day		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 4/13		20g. (County) 4/24		20h. (State) 1962	
21. I certify that (I) (this hospital) attended the deceased from 4/13 , 19 62 , to 4/24 , 19 62 ; that (I) (we) last saw the deceased alive on 4/24 , 19 62 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.					
22a. SIGNATURE John E Baybutt		22b. DATE SIGNED 4-27-62		22c. PHYSICIAN'S NAME (Type) JOHN E BAYBUTT	
22d. ADDRESS 205 Earle Ave Easton, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 4-26-62		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City, town or county) (State) Marydel, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais Greensboro, Md.		25a. REC'D BY REGISTRAR MAY 2 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

0202

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
05058
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05056

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. LENGTH OF STAY IN 1b <u>1 WK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIO-VISTA NURSING HOME</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>L.</u> Last <u>HARRISON</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26, 1873</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RITTED BLACKSMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST. MICHAELS, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN HAMBLETON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Sara Crockett, Oxford Md</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cachexia, uremia, pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4-20-1962</u> to <u>4-27-1962</u> that (I) (we) last saw the deceased alive on <u>4-27-1962</u> and that death occurred at <u>4:58</u> p.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry M. Reeser, Jr.</u>		22b. DATE SIGNED <u>4-29-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry M. Reeser, Jr.</u>		22d. ADDRESS <u>St. Michaels Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried April 30-62</u>		23b. DATE THEREOF <u>April 30-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chino Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Michaels. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hambleton Harrison</u>		25a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>St. Michaels Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

2000

CERTIFICATE OF DEATH

22022

Attest: _____
Notary Public
My Comm. Expires _____
I hereby certify that _____
was born _____
at _____
and died _____
at _____
on _____
at the age of _____
years and _____
months and _____
days.
Witness my hand and seal
this _____ day of _____
19____.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05059

CERTIFICATE OF DEATH

Items 23c & d, Film Q311 4/13/62 iwk

05057

1. PLACE OF DEATH a. COUNTY TALBOT		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 6 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY Talbot		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOZMAN		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD FRANK JACKSON		First		Middle		Last		4. DATE OF DEATH 4 7 1962		Month		Day		Year	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 27 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY SUMMER GUEST HOME		11. BIRTHPLACE (County & State, or foreign country) COATESVILLE, PA		12. CITIZEN OF WHAT COUNTRY U.S.A									
13. FATHER'S NAME BENJIMAN JACKSON		14. MOTHER'S MAIDEN NAME MARY MANN													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-32-0909		17. INFORMANT Mary E. Jackson, Bozman, Md		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 4-9-62 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 wks 1 wk													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cochexia generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bozman		20g. (County) Talbot		20h. (State) Md					
21. I certify that (I) (this hospital) attended the deceased from 17 March 1962 to 7 April 1962 that (I) (we) last saw the deceased alive on 7 April 1962 and that death occurred 4:30 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Arthur S. Kraus		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-9-62									
22c. PHYSICIAN'S NAME (Type) Arthur S. Kraus				22d. ADDRESS St Michaels md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Fair View Cem.		23d. LOCATION (City, town or county) Coatesville, Penna		23e. (State) Penn							
24. FUNERAL DIRECTOR'S SIGNATURE A. Hamilton Harrison		ADDRESS St. Michaels md.		25a. REC'D BY REGISTRAR APR 11 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u> c. LENGTH OF STAY IN 1b <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>TRAPPE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution/Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Addison</u> Middle <u>Jenkins</u> Last <u>Jenkins</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u># Sept. 23, 1875</u> 86 yrs.
9. AGE (In years last birthday) <u>86</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>315-26-5163</u>	
17. INFORMANT <u>George A. Jenkins - Phila. 31, PA.</u>		Address <u>Phila. 31, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>153.8</u> DUE TO (c) <u>153.8</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease-Cardiac Decompensation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 16, 1962</u> , to <u>April 17, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1962</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Edwin Fassett</u>		22b. DATE SIGNED <u>April 17, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>		22d. ADDRESS <u>227 Pine St., Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-21-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sanderstown Cem.</u>	23d. LOCATION (City, town or county) (State) <u>TRAPPE md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Basell</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
DATE <u>MAY 2 '62</u>		DATE <u>MAY 2 '62</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05061
CERTIFICATE OF DEATH
05059

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural- Easton				c. LENGTH OF STAY IN 1b 15 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 50				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nora Middle Matilda Last Jones				4. DATE OF DEATH Month April Day 11 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1887	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min.		IF UNDER 24 HRS. Hours 74 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY Housewife			
11. BIRTHPLACE (County & State, or foreign country) Talbot County, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George T. Sinclair				14. MOTHER'S MAIDEN NAME Rowena Harrison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. UKN.			
17. INFORMANT Curtis H. Jones, Route 50, Easton, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/18 , 19 57 , to 4/12 , 19 62 , that (I) last saw the deceased alive on 8/11 , 19 61 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE L. J. Eglseder M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/12/62	
22c. PHYSICIAN'S NAME (Type) L. J. Eglseder				22d. ADDRESS 12 N. Hanson St., Easton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/62		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town or county) (State) Easton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Carroll				ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR APR 17 1962	
				25b. REGISTRAR'S SIGNATURE W. Hampton Carroll			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05062

05060

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 EASTON,</u> d. STREET ADDRESS <u>1 308 S. WASHINGTON ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN b <u>31 days</u>			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clifford Bowen Jump</u>			4. DATE OF DEATH Month Day Year <u>April 1 1962</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 26, 1881</u>	9. AGE (If years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT MARYLAND</u>		
13. FATHER'S NAME <u>JOHN V. JUMP</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME <u>SUSAN E. SHANNAHAN</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>247-03-7845</u>			17. INFORMANT Address <u>MRS. MYRTLE S. JUMP, EASTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Infection</u> 527. } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Obstructive Emphysema - years</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (e) <u>Upper Respiratory Infection</u>						INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		20g. (County)		20h. (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1961</u> to <u>April 1, 1962</u> ; that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>April 1, 1962</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.						
22a. SIGNATURE <u>L. J. Eglseder</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. DATE SIGNED <u>4/2/62</u>			22c. PHYSICIAN'S NAME (Type) <u>L.J. Eglseder, M.D.</u>			
22d. ADDRESS <u>Easton, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>APRIL 3, 62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		
23d. LOCATION (City, town or county) <u>Easton</u>		23e. (State) <u>MD</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kline</u>			25a. REC'D BY REGISTRAR DATE <u>APR 5 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>						

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Approved: [Signature]

J. A. [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

05063

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05061

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTON Memorial Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) STRAPPE d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First S Middle TROTH Last Kemp			4. DATE OF DEATH Month April Day 23 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 8, 1892	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER & FILLING OWNER			10b. KIND OF BUSINESS OR INDUSTRY STATION		11. BIRTHPLACE (County & State, or foreign country) TALBOT MD
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME ALFRED KEMP		
14. MOTHER'S MAIDEN NAME MARTHA HUGHLETT			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. 218-24-4279			17. INFORMANT Address MARLELLIE KEMP TRAPPE MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO acute myocardial infarction Conditions, if any, which gave rise to immediate cause (b) 4201 DUE TO 4201 (c) 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyperlipidemia					INTERVAL BETWEEN ONSET AND DEATH 6 hr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/23 to 4/23 , 19 62 , that (I) (we) last saw the deceased alive on 4/23 , 19 62 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Thurston Harrison M.D.			22b. DATE SIGNED 4/25/62		
22c. PHYSICIAN'S NAME (Type) Thurston Harrison			22d. ADDRESS Easton, Maryland		
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE WHEREOF april 25, 1962		23c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEM.	
23d. LOCATION (City, town or county) EASTON MD		23e. (State)		23f. (County)	
24. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Neumann & Son ADDRESS Easton, Md.			25a. REC'D BY REGISTRAR DATE APR 30 '62		
25b. REGISTRAR'S SIGNATURE Arthur E. Hanna			25c. (State)		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05064 CERTIFICATE OF DEATH 05062

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN <u>46</u> da	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>x Trappe</u>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Alldaway</u> Last <u>Leonard</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 15, 1889</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Cashier (Bank)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James M. Leonard</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Berry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-4658</u>	
17. INFORMANT <u>Miss Catherine Leonard Trappe Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1962</u> to <u>April 15, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 15, 1962</u> , and that death occurred at <u>7:15 AM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>William L. Winters</u> M.D.	
22b. DATE SIGNED <u>4/15/62</u>		22c. PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>	
22d. ADDRESS <u>210 E DOVER EASTON MARYLAND</u>		22e. SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 17, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cmn.</u>		23d. LOCATION (City, town or county) (State) <u>Easton Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Neumann & Son</u>		25a. REC'D BY REGISTRAR <u>APR 19 '62</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

050020

CLASSIFICATION

050020



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05063

CERTIFICATE OF DEATH

05063

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>8 da</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u> d. STREET ADDRESS <u>17X-2</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>M.</u> Last <u>Massey</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25 - 1901</u>
9. AGE (in years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HARRISON D. MASSEY</u>		14. MOTHER'S MAIDEN NAME <u>SARAH McWHORTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>217-01-7889</u>	
17. INFORMANT <u>DOROTHY P. MASSEY - CHURCH HILL MD.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, right lower lobe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> (c) <u>Healed Pulmonary tuberculosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>002.5</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u> </u> 19 <u> </u> , to <u> </u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>E.C.H. Schmidt</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>17 April 1962</u>
22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>	23d. LOCATION (City, town or county) <u>Church Hill</u> (State) <u>MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar S. Lane</u>		ADDRESS <u>Church Hill Md.</u>	25a. REC'D BY REGISTRAR <u>APR 18 '62</u>
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		DATE <u>APR 18 '62</u>	

13003

CERTIFICATE OF DEATH

13003

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN lb <u>2 hrs. 5 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u> d. STREET ADDRESS <u>05X2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilford</u> Middle <u>WALBERT</u> Last <u>MORRIS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1962</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1910</u>		9. AGE in years <u>51</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REARING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>WON</u>		13. FATHER'S NAME <u>BROOKFORD MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. WALBERT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. WILFORD MORRIS, DENTON</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO (b) <u>Thrombosis left coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> e.m. <u> </u> p.m. <u> </u>					
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>1962</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1962</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>E. C. H. Schmidt</u> M.D.				22b. DATE SIGNED <u>7 April 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>APR. 10, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>			
23d. LOCATION (City, town or county) (State) <u>HILLSBORO, MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u> </u>					
25a. REC'D BY REGISTRAR DATE <u>APR 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05067

05065

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>09X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Jasper</u> Middle <u>Matthew</u> Last <u>Neal</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 4, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bakery Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dorchester County, Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Neal</u>		14. MOTHER'S MAIDEN NAME <u>Annie Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>201-05-6441</u>	
17. INFORMANT <u>Mrs. Jasper Neal, Williamsburg, Maryland</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) <u>Retropneumothorax</u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <u>April 1, 1962</u> to <u>April 1, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 1, 1962</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>2 April 1962</u>
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 4, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	23d. LOCATION (City, town or county) (State) <u>Near Hurlock, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson, Sr.</u> ADDRESS <u>Federalburg, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 6 '62</u> DATE	25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>

05063

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ST. MICHAELS (RURAL) c. LENGTH OF STAY IN b 3 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RIO VISTA NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DEL. b. COUNTY SUSSEX c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) REHOBETH d. STREET ADDRESS 36 WILMINGTON AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) M. First Middle Last KEMP NEWNAM		4. DATE OF DEATH APR. 30 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 17, 1887
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY TALBOT CO. MD	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM BARTLETTE NEWNAM		14. MOTHER'S MAIDEN NAME EDITH PARSONS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-32-6930	
17. INFORMANT M. Kemp Newnam		Address Rehoboth Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 177X DUE TO Cochepia - severe Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO carcinoma prostate with widespread metastases - stomach, liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-24 19 62 to 4-30 19 62 that (I) (we) last saw the deceased alive on 4-30 19 62 and that death occurred at 9 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Mary M. Beeser J M.D.		22b. DATE SIGNED 5-2-62	
22c. PHYSICIAN'S NAME (Type) Mary M. Beeser J		22d. ADDRESS St Michael's Md	
23a. BURIAL, CREMATION, or DISPOSITION (Specify)	23b. DATE THEREOF May 3, 1962	23c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEM.	23d. LOCATION (City, town or county) (State) EASTON MD.
24. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son.		25a. REC'D BY REGISTRAR MAY 4 '62 DATE	
ADDRESS Easton Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05069

05067

1. PLACE OF DEATH e. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALDAN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton Memorial		d. STREET ADDRESS 43 S. SYCAMORE AVE.	
3. NAME OF DECEASED (Type or print) Julia Hyatt Price		4. DATE OF DEATH April 22 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-1897
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier U. of P. Dental School		10b. KIND OF BUSINESS OR INDUSTRY NEW CASTLE CO. DELAWARE	
11. BIRTHPLACE (County & State, or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES WESLEY PRICE		14. MOTHER'S MAIDEN NAME ROSA LEE DAUBMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 302-22-4432	
17. INFORMANT ELIZABETH M. PRICE		Address 43 S. SYCAMORE AVE ALDAN, PA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 416 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease mitral DUE TO (c) (?)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 22 Apr 1962 , to 22 Apr 1962 , that (I) (we) last saw the deceased alive on 22 Apr 1962 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE HURSTON HARRISON		22b. DATE SIGNED 22 Apr 62	
22c. PHYSICIAN'S NAME (Type) HURSTON HARRISON		22d. ADDRESS Easton Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-26-62	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Arlington Cem.	23d. LOCATION (City, town or county) (State) Delaware Co Pa.
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25a. REC'D BY REGISTRAR APR 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

2702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05070

CERTIFICATE OF DEATH

05068

Information from birth cert.

1. PLACE OF DEATH a. COUNTY TALBOT				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Caroline			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Denton		d. STREET ADDRESS Rt. #3 Box 44	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Easton Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Simpson				4. DATE OF DEATH Month April Day 21 Year 1962			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 19, 1962	
9. AGE (in years last birthday) 2		IF UNDER 1 YEAR Months 2 Days 2		IF UNDER 24 HRS. Hours 2 Min. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME MORRIS SIMPSON				14. MOTHER'S MAIDEN NAME KATIE HILL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Morris Simpson Address Denton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Endocardial Fibrosis 7544 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/19 , 19 62 , to 4/21 , 19 62 ; that (I) (we) last saw the deceased alive on 4/21 , 19 62 , and that death occurred at 12:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE E. C. H. Schmidt				M.D. E. C. H. Schmidt		22b. DATE 22 April 1962	
22c. PHYSICIAN'S NAME (Type) E. C. H. Schmidt				22d. ADDRESS Denton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Apr 23, 1962		23c. NAME OF CEMETERY OR CREMATORY Denton		23d. LOCATION (City, town or county) (State) Denton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Virgin Moore				ADDRESS Denton		25a. REC'D BY REGISTRAR APR 25 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. ...			

26-059665

05088

CLINTON COUNTY

05070

1947

1947

1947

Franklin Memorial Hospital

Pay

Pay

Pay

Franklin Memorial Hospital

Pay

Franklin Memorial Hospital

Pay

Pay

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05071

05069

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>16 hrs 10 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> d. STREET ADDRESS <u>River Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>MICHAEL ALLEN STANLEY</u>			4. DATE OF DEATH Month Day Year <u>4 1 19 62</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>February 23, 1962</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>8</u>		IF UNDER 1 YEAR Months Days <u>1</u> <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Mervin E. Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Erma Ricketts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Evelyn Ricketts, Federalsburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Mal nutrition; Dehydration</u> (c) <u>Diarrhea</u> DUE TO cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 wk</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-31</u> , 19 <u>62</u> , to <u>4-1</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-1</u> , 19 <u>62</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>John E Baybutt</u> M.D.			22b. DATE SIGNED <u>4-2-62</u>		
22c. PHYSICIAN'S NAME (Type) <u>John E. Baybutt, M.D.</u>			22d. ADDRESS <u>205 Earle Ave EASTON, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 2, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill</u>	
23d. LOCATION (City, town or county) <u>Federalsburg, Maryland</u>		23e. (State)		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton & Son</u>			24b. ADDRESS		
25a. REC'D BY REGISTRAR DATE <u>APR 6 '62</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>		

(M)

(1)

John E. Smith, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05072					05070									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		Talbot			a. STATE		Maryland							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		rural- Easton			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		rural- Easton							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Chapel Road			d. STREET ADDRESS		Chapel Road							
e. IS RESIDENCE ON A FARM?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First		Middle		Last		Month		Day Year						
Annie		E---		Stinson		April		26 19 62						
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Female		White		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		May 28, 1881		80 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?								
housework		housewife		England		<input checked="" type="checkbox"/> USA <input type="checkbox"/> England								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
John W. Vesty					Elizabeth Bell									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
no none					218 20 4049					Mrs. Jessie Voshell, Easton, RD, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease with myocardial insufficiency										more than ten years				
DUE TO (b) Hypertensive cardio-vascular disease										15 years				
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) Diabetes mellitus														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)				
Hour e.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
21. I certify that (I) (this hospital) attended the deceased from Oct. 20, 1947 to April 26, 1962 that (I) (we) last saw the deceased alive on April 26, 1962, and that death occurred 11 A.M. from the causes and on the date stated above.														
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED				
Kurt Lederer					MD					Queen Anne, Md.				
22c. PHYSICIAN'S NAME (Type)														
Kurt L. Lederer					MD									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)					
Burial			4/29/62			Greenmount Cemetery			Hillsboro, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
W. Frampton Carroll						Easton, Md.			MAY 1 '62 Arthur S. Hume					

05050

05050

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05073
05071

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>61 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>416 South St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 30, 1893</u>		9. AGE (in years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Co. md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Coursey</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>816-093870</u>				17. INFORMANT <u>Novella Thomas</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Hypertensive Encephalopathy</u> DUE TO (b) <u>Hypertensive Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>29 April 62</u> to <u>30 April 62</u> , that (I) (we) last saw the deceased alive on <u>30 April 1962</u> and that death occurred at <u>2</u> P.M. from the causes and on the date stated above.																					
22a. SIGNATURE <u>R. Lane Wroth</u>												22b. DATE SIGNED <u>30 April 62</u>				22c. PHYSICIAN'S NAME (Type) <u>R. LANE WROTH</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MAY 5, 1962</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Hall</u>												25a. REC'D BY REGISTRAR <u>MAY 3 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>					

05013

CERTIFICATE OF DEATH

05013

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05074
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>EASTON</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Easton Memorial Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> 29 d. STREET ADDRESS <i>Cleifton</i> 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Perry</i> Middle <i>E</i> Last <i>Wightman</i>		4. DATE OF DEATH Month <i>April</i> Day <i>30</i> Year <i>1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1903</i>
9. AGE (In years last birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mfr. Electronic Equipment</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>M. Rainer Maryland</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>W. S.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph Wightman</i>		14. MOTHER'S MAIDEN NAME <i>Bernice Bufalo</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>577-05-0730</i>	
17. INFORMANT <i>Mrs. Lillian Wightman</i>		Address <i>Easton Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Intra cranial Neoplasm not ruled out</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4/28/62</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/26</i> , 19 <i>62</i> , to <i>4/30</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>4/30</i> , 19 <i>62</i> , and that death occurred at <i>6:15</i> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>L. J. Eglseder</i> M.D.		22b. DATE SIGNED <i>4/30/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>L. J. Eglseder</i> M.D.		22d. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 3, 1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Memorial Pk.</i>		23d. LOCATION (City, town or county) (State) <i>Easton Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Howard & Son</i>		25a. REC'D BY REGISTRAR <i>DATE MAY 4 '62</i>	
ADDRESS <i>Easton Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05075 CERTIFICATE OF DEATH 05073

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RE 4 EASTON</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> d. STREET ADDRESS <u>Rt. 4 - Box 62</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>A.</u> Last <u>Wisher</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>11</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7, 1906</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Bailey</u>	
14. MOTHER'S MAIDEN NAME <u>MARY E. Dickerson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>820-10-6301</u>		17. INFORMANT <u>William W. Wisner</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from left middle cerebral Artery</u> DUE TO (b) <u>Hypertensive Encephalopathy</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4 4 3 X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs</u> <u>many yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1953</u> to <u>4/10, 1962</u> that (I) (we) last saw the deceased alive on <u>4/10, 1962</u> and that death occurred at <u>3:38 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Shepard Krech Jr</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/13/62</u>
22c. PHYSICIAN'S NAME (Type) <u>Shepard Krech Jr</u>		22d. ADDRESS <u>EASTON, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sanderstown Cem.</u>	23d. LOCATION (City, town or county) (State) <u>TRAPPE Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Goodrich - Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 18 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

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